Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 1/17/12
Amount 2505.00

#035790

I. IDENTIFICATION

Name: Baptist Convalescent Center

Address: 120 Main Street

City/County/Zip: Newport, Ky 41071

Telephone number: 859-581-1938

Administrator: Donna Frodge

Date facility operation began at current address: 1952

Date facility began operation under current owner: 1952

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	167	
Nursing Home		
Nursing Facility		
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit	Individual
County	(Nonprofit)	Partnership
City		Corporation
Private		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Baptist Life Communities
1452 Donaldson Highway
Erlanger, Ky 41018

(OVER)

RECEIVED
JAN 17 2012
OFFICE OF INSPECTOR GENERAL

1/51

If facility owned or leased by a corporation, complete the following:

Name of corporation Baptist Convalescent Center, Inc

Address of corporation 1452 Donaldson Highway, Erlanger, Ky 41018

President or Chairman Dr. Robert Long - CEO

Vice President Robert Kester - CFO

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	_____
_____	_____
_____	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Donna Prodge, LNHA — Signature of authorized representative

Administrator — Title

1-9-12 — Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)